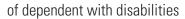
Application for Coverage





Section 1 – Member Information							
First Name	MI	Mailing Address (if different from residential address)					
Last Name	Suffix	City					
Residential Address		State	ZIP Code	+4			
City		Member	ID Number				
State ZIP Code +4 County		Social Se	ecurity Number				
Section 2 – Dependent With Disabilities Information	n						
Et a.M.							
First Name	MI	Resident	ial Address				
Last Name	Suffix	City					
Date of Birth		State	ZIP Code	+4	County		
Is the dependent married?						□Yes	□No
Relationship to applicant: Child Stepchild	☐ Leg	al Guard	ianship 🗆	Legal Custoo	dy		
Are you responsible for the chief support and main	ntenanc	e of the	dependent?			□Yes	□No
Is dependent an established beneficiary under Me If yes, only complete Sections 1 and 2 and submit verifi			-	,		□Yes	□No
Has the dependent had any income during the pas If yes, please provide the following information:	st year?					□Yes	□No
Source of Income	List other members of the healthcare team (i.e., specialist in rehabilitation or mental health care):						
Amount of Income							
Physician's Name							
Your signature required Member's Signature					– — — / Date Sig	//_	

If you have dependent life coverage through Advance Insurance Company of Kansas (AICK), please fill out Form AICK 21 – Dependent with Disabilities Application Form and forward to AICK.

Section 3 – Informa	tion to be o	completed by phys	sician		
Diagnosis of condition	n causing	disability; indicat	e the severity:		
1 1					
Date Dependent Last Treate	d				
Prognosis (estimate	in months	or years):			
Is dependent incapable of self-support by reason of mental or physical disability?			□Yes	□No	
Is dependent now confined to an institution?				□Yes	□No
If yes, please provide t	:he informa	tion below:			
Name of Institution					
Physician's Address					
City					
State ZIP Code	+4	County			
Your signature required				/ /	
	Physician's	s Signature		Date Signed	

Section 4 – Dependent with Disabiliites Qualifications for Eligibility

- » The dependent must be incapable of self-sustaining employment by reason of physical disability or by reason of cognitive, intellectual or developmental disabilities or emotional illness if the member has legal guardianship or conservatorship of the dependent due to the cognitive or emotional illness.
- » The dependent must be chiefly dependent upon the member for support and maintenance.
- » At the time application for disability coverage is made, the dependent must be unmarried and at the age listed as the maximum age for dependents in the insurance contract unless otherwise stated in the contract. The dependent, if approved for disabled dependent status, will lose coverage if he/she marries unless the member continues after the marriage to have guardianship or conservatorship of the dependent due to the dependent's cognitive, intellectual or developmental disabilities or emotional illness.
- » The member must be covered under a family policy.
- » Coverage will be considered only for dependents who would otherwise be covered by a family policy as dependents of the member.
- » Approval or disapproval will be determined by Blue Cross and Blue Shield of Kansas, Inc., and will be based upon the information provided on application for coverage or otherwise available or made available to Blue Cross and Blue Shield of Kansas, Inc.

Please complete this form and return to:

Blue Cross and Blue Shield of Kansas, Inc. 1133 SW Topeka Blvd. Topeka, KS 66629-0001